Journal of Biology, Agriculture and Healthcare
ISSN 2224-3208 (Paper) ISSN 2225-093X (Online)
Vol.6, No.6, 2016

Do Not Resuscitate (DNR) Order among Terminally Ill Patients with Cancer: A Position Statement

Batool Al-Masri [1] Majd Mrayyan [2]
1. Master of Oncology Nursing, Hashemite University, Faculty of Nursing, AL-Zarqa, Jordan
2.Dean of Scientific Research, Consultant of Nursing, Hashemite University, P.O. Box 150459, AL-Zarqa 13115, Jordan

Abstract
End-of-life (EOL) care takes an important place in critical care settings. Of it, one of the most serious and arguable decision is the Do Not Resuscitate (DNR) order. The DNR is a legal order written by a licensed physician in consultation with the patients or their surrogate decision makers, in which the cardiopulmonary resuscitation (CPR) is withhold at the time of cardiac or respiratory arrest. Many studies reported that many inpatient deaths had a DNR order. The purpose of this position statement paper is to present proponents and opponents' viewpoints regarding the DNR orders for terminally ill patients with cancer. Proponents of the DNR order reported that it is a form of treatment that protects patients' rights, and allows the terminally ill cancer patients to die peacefully without undergoing futile resuscitation attempts. Opponents of the DNR order are concerned with the protection and preservation of life of the terminally ill cancer patients. The current author is against the DNR order based on the patients' right for sanctity of life, and the Islamic views of human life.
Keywords: Do Not Resuscitate, Do Not Resuscitate Order, DNR, Cancer, Position Statement, Proponents, Opponents.

1. Introduction

Globally, cancer is one of the leading causes of death (Fitzmaurice et al., 2015; World Health Organization [WHO], 2012). It is a pandemic disease with an increasing prevalence rate worldwide (American Cancer Society [ACS], 2015; Jacox, Daniel, & Payne, 1994).

There is a tremendous progress in developing treatments that improved life expectancies for patients with advanced-stage cancer (ACS, 2015). From 2003 to 2007, the Dartmouth Atlas Project analyzed Medicare data for cancer patients older than 65 years who died within one year of diagnosis, reported that 29% of patients died in a hospital in United States of America (USA), 61% of patient with cancer hospitalized at least once in the last month of life (Goodman et al., 2010), and that the survival rate after CPR did not change substantially (Ehlenbach et al., 2009).

Therefore, EOL care is essential in critical care settings; however, the DNR order remains a controversial clinical issue. To be legal, the DNR order should be written by a licensed physician in consultation with a patient or surrogate decision maker (Khalaileh, 2014; Miljković, Emuron, Rhodes, Abraham, & Miller, 2015; Robinson, Kolesar, Boyko, Berkowitz, Calam, & Collins, 2012). In the DNR order, the CPR is withhold at the time of cardiac or respiratory arrest (Khalaileh, 2014; Thibault - Prevost, Jensen, & Hodgins, 2000; Miljković et al., 2015; Robinson et al., 2012). However, the DNR order does not require stopping all forms of medical and nursing interventions; patients continue to receive intravenous fluids, comfort medication, antibiotics, and other palliative care (Khalaileh, 2014).

By the mid-1970s, the DNR practice was recognized by the American Heart Association (AHA), and the DNR orders have been governed by legislation since the 1980s in the USA (Bishop, Brothers, Perry, & Ahmad, 2010; Braddock, & Clark, 1998).

Utilizing a sample of patients with advanced cancer stages, a retrospective study reported that about 86% of inpatient deaths had a DNR order in 2005 (Levin et al., 2008), 76% of patients had a DNR order in 2010 (Kizawa, Tsuneto, Hamano, Nagaoka, Maeno, & Shima, 2013), it ranged between 63%–71% in 2015 (MiljkovićMiloš, 2015).

A position statement is a detailed statement by an independent panel of experts, which usually explains or suggests a particular course of action regarding an issue that articulates a position or policy (Canadian Psychological Association [CPA], 2012). It contains background information and examination in order to provide a more complete understanding of the issues involved (American Heritage, 2011; CPA, 2012; Ingravallo, Dietrich, Gilja, & Piscaglia, 2014). The purpose of this position statement paper is to present proponents and opponents' viewpoints regarding the DNR order for terminally ill patients with cancer. It is mindful to report at this stage that the current author opposes the DNR order.

2. Background

Confusion arises in discussions and decision making about EOL issues including the DNR orders (Kasule, 2012). However, starting 1988, DNR policies become a necessity to meet the accreditation standards of hospitals in the

USA (Bishop et al., 2010 ; Robertson, 1993).

Worldwide, the DNR order has been used in hospitals for over 20 years (Yuen, Reid, & Fetters, 2011). The largest study which retrospectively examined a stratified sample (13,883) of all death in the USA since 1986, excluding trauma and perinatal deaths, reported that the DNR order was written in 9.8% of overall deaths and 16% of cancer deaths (Hanson & Rodgman, 1996). In 2005, 86% of inpatient deaths and 52% of outpatient patients' deaths had a DNR order; yielding a 24% increase over 6 years. About 53% of the DNR orders were signed by the patients themselves, while 34% were signed by surrogate decision makers (Levin et al., 2008). In a retrospective study, Azad, Siow, Tafreshi, Moran, and Franco (2014) reported that medical interventions continued in 80% of patients with cancer after placing the DNR orders including blood draws, intravenous antimicrobials, blood products, imaging, and radiotherapy. The researchers reported also that 75% of patients with the DNR order survived and were discharged alive.

The purpose of the following literature review is to pinpoint different proponents and opponents' positions regarding the DNR orders for patients with cancer.

2.1. Proponents of the DNR Order

The American Academy of Nursing (AAN) stressed on the EOL discussion as an essential component in the care of all patients, especially for those with critical and chronic conditions (AAN, 2010; The Palliative and End of Life Care Expert Panel, 2013). The Institute of Medicine (IOM) (2014) supports the importance of having such conversations with patients in their recent report titled "*Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life*."

In the 1990s, at least in the USA based on the Patient Self Determination Act (PSDA), there was a consensus on the patient's right to refuse treatment given that refusing treatment may lead to death (Koch, 1992; Bishop et al., 2010). Thus, CPR, along with its rejection—DNR orders—began to be perceived as one of the options among other the choices available for the patients and their families (Blackhall, 1987; Carson & Siegler, 1982). In turn, the DNR order could be embedded in the patient's choice paradigm and called a "patient order" not to attempt resuscitation (Bishop et al., 2010).

In oncology, the majority of health care providers believe on that patients with cancer have very poor survival rates after cardiopulmonary arrest. Therefore, considerable efforts have been made to increase the use of DNR order in patients with advanced cancer stages to avoid this futile and distressing intervention (Azad et al., 2014; Reisfield, Wallace, Munsell, Alvarez, & Wilson, 2006).

In the Islamic religion, concepts related to the DNR order have been clarified by the Presidency of the Administration of Islamic Research and Ifta in Saudi Arabia, in their Fatwa No. 12086 issued on 30.6.1409 (Hijra). The Fatwa states that: "if three knowledgeable and trustworthy physicians agreed that the patient's condition is hopeless; the life-supporting machines can be withheld or withdrawn" (Administration of Islamic Research and Ifta, 1988). Furthermore, the Islamic Medical Association of America (IMANA) showed that when death becomes inevitable, as determined by physicians, the patient should be allowed to die without unnecessary procedures (IMANA, 2005).

Based on the above Fatwa, many hospitals in the Islamic world have developed policies such as a "No Code" policy in Saudi Arabia (Appendix 1) (Takrouri & Halwani, 2008), a DNR policy in King Hussein Cancer Center (KHCC) in Jordan. The latest states that "All terminally ill cancer patients are considered eligible and have the right to a DNR directive" (KHCC, 2004).

Many studies supported the DNR order to allow terminally ill patients to die peacefully (Oh et al., 2004). In addition to that, sometimes the CPR does not offer direct clinical benefits, either because the resuscitation will not be successful or lead to co-morbidities which will prolong suffering without reversing the underlying disease (Burns & Truog, 2007). The probability of survival, patient's wishes, previous quality of life and expected quality of life after the diagnosis are the main factors influences the use of DNR orders (Sham et al., 2007).

2.2. Opponents of the DNR Order

In 1997, the IOM released a report on the state of EOL care in the USA (Field, & Cassel, 1997). Since that time many of the IOM's indictments have been handled through the expansion of palliative hospice care (Singer, 2015). According to National Priorities Partnership (2008), there is a special need for EOL care for patients facing life-limiting illnesses as they deserve the highest level of quality and compassionate care. Attention should be given regarding three main goals: planning for the prevention, treatment of pain, and continuity of care.

Previously, there are no clear guidelines for the DNR orders. In turn, some physicians refused the DNR order considering the barriers to carry out such an order. These barriers included the lack of planning of patient-centered advance care, and the unwillingness of many health care providers to discuss the DNR order with the patients and their families because of health care providers' discomfort with the topic, and lack of training or

time to such discussion (Siddiqui & Holley, 2011).

Currently, many health care societies have issued statements regarding the use of DNR order. As the disease progresses and advanced stages of cancer exist, all patients have to deal with the end of life decision as whether to attempt CPR. In different countries, the EOL decision including the DNR order is made between the physician and the patient or/and a family member. Such a shared decision making is less common; it is unethical for any health care provider to make a unilateral decision; it relates to a critical issue of a patient's life (Kizawa et al., 2013; Oh et al., 2006). There is always a possible conflict in decision making between health care providers and patients or their families. A study showed that 42% of no agreement between patients' families and physicians' attitudes toward CPR (Jaul, Zabari, & Brodsky, 2014).

The DNR order does not mean ultimately hopelessness. In a recent study, 66% of hospitalized patients with cancer who had DNR orders were discharged home, and that 63% were alive at 30 days after a DNR order was written (Azad et al., 2014). Additionally, a recent Swedish newspaper reported that a 41-year-old man, who had been in a coma for three weeks, was coded as "DNR", and when respiratory arrest occurred, he was resuscitated by his father. After which the health care providers resume life support treatments and finally the patient recovered (Lützén & Ewalds-Kvist, 2013).

Culture should be taken into account when discussing the DNR order. Only 14.4% of South Korean family members permit physician's access to the patient with advanced stage of cancer for the discussion of EOL decisions including the DNR order (Oh et al., 2006). Furthermore, Japanese oncologists have greater negative attitudes regarding withhold life-support care (DNR) than American for terminally ill cancer patients, and reported that it will be never be ethically justified (Kizawa et al., 2013).

In summary, the purpose of this literature review was to address different proponents and opponents' positions regarding the DNR order for terminally ill patients with cancer. The DNR order is one of the EOL debatable issues around the world. Supported by many studies, it is the patient's right to ask for such treatment as it allows the terminally ill patients to die peacefully without undergoing effortless resuscitation attempts. On the other hand, opponents of the DNR orders considering protection and preservation of life of terminally ill patients including advance stages of cancer.

3. Position Statement

For many years, the DNR practice clearly involves ethical and legal considerations as well as medical and economical decisions.

The current author opposes the DNR order taking into account the saying of Prophet Muhammad - Peace Be Ubon Him (PBUH)-: 1-There is no disease that God has created, except that He also has created its treatment; 2- Prophet Muhammad (PBUH) also said: Seek treatment, for God the Exalted did not create a disease for which He did not create a treatment, except senility. This is also a further emphasis on the "Goals of the Islamic Shari`ah"; the protection and preservation of life. These evidences support that the person has the right to live even if he/she is terminally ill including those with advances stages of cancer.

When physicians make the DNR order unilaterally without taking patient's consent, it would never be ethically justified as it insulted the patient's right to live. Health care providers should adopt a professional role to prolong patient's life, and protect his/her value system of the ''sanctity of life''.

Many recommendations could be probably help to handle one of the most important EOL decisions; the DNR order. These include:

- The patient has the right to understand all the legal, ethical, and religious aspects of the DNR order.
- Efforts are needed to normalize conversations about death and dying to pursue high quality care for the patients.
- Nurses should be act as advocators for the patients regarding the DNR order.
- Health care providers should continue to revisit advance care planning discussions with their patients because individuals' preferences and circumstances may change over time.
- Health care providers should respect the patients' rights in decision making regarding EOL issues including the DNR order rather than their family members.
- Health care providers should inform the patients that there was a significant percent of patients with DNR orders were discharged alive.

4. Summary and Conclusion

Worldwide, for many decades, numerous discussions were done regarding EOL decisions, accompanied with continuing debates and confusion about such topic including the DNR order. This position statement pinpointed different proponents and opponents' positions regarding the DNR order for terminally ill patients with cancer. The current author believes in sanctity of life, and thus she views that the DNR order will never be ethically justified.

5. Acknowledgement
First and above all, I praise God, the almighty for providing me this opportunity and granting me the capability to proceed successfully. Also, the current author would like to express her sincere gratitude to Professor Dr. Majd Mrayyan for her kindness, helpfulness and her ceaseless encouragement with valuable insight and guidance. I would like to thank my lovely family because this work would not have come to fruition without their support.

References

Administration of Islamic Research and Ifta. (1988). Fatwa No. 12086 issued on 30.6.1409 (Hijra). Riyadh, KSA.

American Academy of Nursing. (2010). *Policy brief: Advance care planning as an urgent public health concern*. Retrieved from http://www.aannet.org/assets/docs/PolicyResources/aan policy brief - advance care planning.pdf.

American Cancer Society. (2015). *Rising global cancer epidemic*. Retrieved from http://www.cancer.org/research/infographicgallery/rising-global-cancer-epidemic

American Cancer Society. (2015). *Cancer facts and figures*. Retrieved from http://www.cancer.org/acs/groups/content/@editorial/documents/document/acspc-044552.pdf

American Heritage. (2011). *Definition of position paper*. Retrieved from http://www.thefreedictionary.com/position+paper

Azad, A. A., Siow, S. F., Tafreshi, A., Moran, J., & Franco, M. (2014). Discharge patterns, survival outcomes, and changes in clinical management of hospitalized adult patients with cancer with a Do-Not-Resuscitate Order. *Journal of Palliative Medicine*, *17*(7), 776-781.

Bishop, J. P., Brothers, K. B., Perry, J. E., & Ahmad, A. (2010). Reviving the conversation around CPR/DNR. *The American Journal of Bioethics*, *10*(1), 61-67.

Blackhall, L. J. (1987). Must we always use CPR?. *New England Journal of Medicine*, *317*(20), 1281-1285.

Braddock, C. H., & Clark, J. D. (1998). *Do not resuscitate orders: Ethical topic in medicine*. Retrieved from https://depts.washington.edu/bioethx/topics/dnr.html

Burns, J. P., & Truog, R. D. (2007). Futility: a concept in evolution. *CHEST Journal*, *132*(6), 1987-1993.

Carson, R. A., & Siegler M. (1982). 1982. Does 'doing everything' include CPR? *Hastings Center Report*, *12*(5), 27–29.

Canadian Psychological Association (2012). *CPA guidelines for policy statements, position and discussion papers*. Retrieved from http://www.cpa.ca/aboutcpa/committees/publicpolicy/cpapublicpolicyguidelines

Ehlenbach, W. J., Barnato, A. E., Curtis, J. R., Kreuter, W., Koepsell, T. D., Deyo, R. A., & Stapleton, R. D. (2009). Epidemiologic study of in-hospital cardiopulmonary resuscitation in the elderly. *New England Journal of Medicine*, *361*(1), 22-31.

Field, M. J., & Cassel, C. K. (Eds.). (1997). *Approaching death: Improving care at the end of life*. National Academies Press. New York, NY: 10011.

Fitzmaurice, C., Dicker, D., Pain, A., Hamavid, H., Moradi-Lakeh, M., MacIntyre, M., & Hamadeh, R. R. (2015). The global burden of cancer 2013. *JAMA Oncology*, *1*(4), 505-527.

Goodman, D. C., Fisher, E. S., Chang, C., Morden, N. E., Jacobson, J. O., Murray, K., & Miesfeldt, S. (2010). Quality of end-of-life cancer care for Medicare beneficiaries: Regional and hospital-specific analyses. *Dartmouth Atlas of Health Care Report Hanover, 23*, 1-51.

Hanson, L.C., & Rodgman, E. (1996). The use of living wills at the end of life: A national study. *Archives of Internal Medicine*, *156*, 1018 – 1022.

Jacox, A., Carr, D. B., & Payne, R. (1994). New clinical-practice guidelines for the management of pain in patients with cancer. *New England Journal of Medicine*, *330*(9), 651-655.

Jaul, E., Zabari, Y., & Brodsky, J. (2014). Spiritual background and its association with the medical decision of, DNR at terminal life stages. *Archives of Gerontology and Geriatrics*, *58*(1), 25-29.

IMANA Ethics Committee. (2005). Islamic medical ethics: the IMANA perspective. *Journal of the Islamic Medical Association of North America*, *37*(1), 5-6.

Ingravallo, F., Dietrich, C. F., Gilja, O. H., & Piscaglia, F. (2014). Guidelines, clinical practice recommendations, position papers and consensus statements: Definition, preparation, role and application. *Ultraschall in der Medizin (Stuttgart, Germany: 1980)*, *35*(5), 395-399.

Institute of Medicine. (2014). *Dying in America: Improving quality and honoring individual preference near the end of life.* Retrieved from http://www.iom.edu/~/media/Files/Report Files/2014/EOL/Key Findings and Recommendations.pdf

Kasule, O. H. K. (2012). Outstanding ethico-legal-fiqhi issues. *Journal of Taibah University Medical Sciences*, *7*(1), 5-12.

Khalaileh, M. A. (2014). Jordanian critical care nurses' attitudes toward and experiences of do not resuscitate orders. *International Journal of Palliative Nursing*, *20*(8), 403-408.

King Hussein Cancer Center. (2004). Medical Ethics Committee. Document No.: POLETC -01R3. Amman.

Kizawa, Y., Tsuneto, S., Hamano, J., Nagaoka, H., Maeno, T., & Shima, Y. (2013). Advance directives and do-not-resuscitate orders among patients with terminal cancer in palliative care units in Japan: A nationwide survey. *American Journal of Hospice and Palliative Medicine*, *30*(7), 664-669.

Koch, K. A. (1992). Patient Self-Determination Act. *The Journal of the Florida Medical Association*, *79*(4), 240-243.

Levin, T. T., Li, Y., Weiner, J. S., Lewis, F., Bartell, A., Piercy, J., & Kissane, D. W. (2008). How do-not-resuscitate orders are utilized in cancer patients: Timing relative to death and communication-training implications. *Palliative and Supportive Care*, *6*(04), 341-348.

Lützén, K., & Ewalds-Kvist, B. (2013). Moral distress and its interconnection with moral sensitivity and moral resilience: Viewed from the philosophy of Viktor E. Frankl. *Journal of Bioethical Inquiry*, *10*(3), 317-324.

Mello, M., & Jenkinson, C. (1998). Comparison of medical and nursing attitudes to resuscitation and patient autonomy between a British and an American teaching hospital. *Social Science & Medicine*, *46*(3), 415-424.

Miljković, M. D., Emuron, D., Rhodes, L., Abraham, J., & Miller, K. (2015). “Allow Natural Death” versus “Do Not Resuscitate”: What Do Patients with Advanced Cancer Choose?. *Journal of Palliative Medicine*, *18*(5), 457-460.

National Priorities Partnership (U.S.) National Quality Forum. (2008). *National priorities & goals: Aligning our efforts to transform America's healthcare*. Washington, DC: National Quality Forum.

Oh, D. Y., Kim, J. E., Lee, C. H., Lim, J. S., Jung, K. H., Seog Heo, D., ... & Kyeong Kim, N. (2004). Discrepancies among patients, family members, and physicians in Korea in terms of values regarding the withholding of treatment from patients with terminal malignancies. *Cancer*, *100*(9), 1961-1966.

Oh, D. Y., Kim, J. H., Kim, D. W., Im, S. A., Kim, T. Y., Heo, D. S., ... & Kim, N. K. (2006). CPR or DNR? End-of-life decision in Korean cancer patients: A single center’s experience. *Supportive Care in Cancer*, *14*(2), 103-108.

Reisfield, G. M., Wallace, S. K., Munsell, M. F., Webb, F. J., Alvarez, E. R., & Wilson, G. R. (2006). Survival in cancer patients undergoing in-hospital cardiopulmonary resuscitation: A meta-analysis. *Resuscitation*, *71*(2), 152-160.

Robertson, G. S. (1993). Resuscitation and senility: A study of patients' opinions. *Journal of Medical Ethics*, *19*(2), 104-107.

Robinson, C., Kolesar, S., Boyko, M., Berkowitz, J., Calam, B., & Collins, M. (2012). Awareness of do-not-resuscitate orders What do patients know and want?. *Canadian Family Physician*, *58*(4), e229-e233.

Sham, C. O., Cheng, Y. W., Ho, K. W., Lai, P. H., Lo, L. W., Wan, H. L., ... & Wong, A. Y. C. (2007). Do-not-resuscitate decision: The attitudes of medical and non-medical students. *Journal of Medical Ethics*, *33*(5), 261-265.

Siddiqui, M. F., & Holley, J. L. (2011). Residents’ practices and perceptions about do not resuscitate orders and pronouncing death: An opportunity for clinical training. *American Journal of Hospice and Palliative Medicine*, *28*(2), 94-97.

Singer, A. (2015). High and worsening symptom prevalence in the last year of life MediCaring.org. Retrieved from http://medicaring.org/2015/02/02/symptom-prevalence/

Takrouri, M., & Halwani, T. (2008). An Islamic medical and legal prospective of do not resuscitate order in critical care medicine. *International Journal of Health*, *7*(1), 11.

Thibault‐Prevost, J., Jensen, L. A., & Hodgins, M. (2000). Critical care nurses' perceptions of DNR status. *Journal of Nursing Scholarship*, *32*(3), 259-265.

The Palliative and End of Life Care Expert Panel. (2013). *Advance care planning as an urgent public health concern*. Retrieved from http://www.aannet.org/policy-brief–advance-care-planning-as-an-urgent-public-health-concern–2013-

World Health Organization. (2012). *WHO: The top 10 causes of death*. Retrieved from http://www.who.int/mediacentre/factsheets/fs310/en/

Yuen, J. K., Reid, M. C., & Fetters, M. D. (2011). Hospital do-not-resuscitate orders: Why they have failed and how to fix them. *Journal of General Internal Medicine*, *26*(7), 791-797.

Appendix (1)
Hospital DNR Policy
Objectives:

1. This Policy shall delineate the meaning and scope of DNR order.
2. This Policy shall determine the patient's condition in which DNR order is applicable.
3. This Policy shall determine who decide and approve the DNR order.

The committee would like to stipulate the difference between the Basic Life Support which cannot be denied at any time for patient from the Advanced Life Support (ventilation support or invasive medications).
Finally, the Committee tried their best to achieve the following guidelines of resuscitation or not to resuscitate order for adults, children and neonates. We ask God for guidance and help during this task and we hope that we have fulfilled and achieve the right conclusions.
Applicability:
This policy shall apply to all adults and pediatric wards including the various Intensive Care Units (ICUs).
Policy:
Coding for resuscitation including cardio respiratory resuscitation (CPR) shall be applied to victims of sudden cardiac or respiratory arrest with reversible causes in whom the treatment carries a reasonable possibility of remission of symptoms and restoration of the patient toward an acceptable functioning integrated existence, not biological vegetative existence.[LIST ONE]
These conditions include: Drowning and near drowning – Suffocation, Electric shock, Lightening, Untoward, effects of drugs, Anesthetic accidents, Heart block and malignant arrhythmias, Acute myocardial infarction Trauma, Surgical complications
In case of doubt, the principle pf “act first and evaluate later” should be applied.
DNR should be considered: if it offers no potential benefit in patient with poor quality of life before cardio respiratory arrest, e.g.:
a. severe mental or physical incapacity.
b. terminal or untreatable chronic diseases which are associated with extremely low chance of survival such as:

- Cancer
- Multi organ failure
- known severe brain damage or brain death
- advanced pulmonary diseases
- Conditions which are associated with extremely low chance of survival for example:
    - Inoperable congenital heart disease.
    - Werding Hoffman disease Spinal muscular atrophy type-one
    - Fatal Chromozomal anomalies
    - Fatal neuromuscular diseases.

Procedure:
It is important to identify all critically ill patients and whose condition which can become potentially so, in those whom CPR is inappropriate. This is the responsibility of caring team led by the consultant.
The caring physician must notify the DNR Committee of his department. All member plus the attending physician must agree on considering that the DNR is applicable for this patient.
In case of delayed report by the attending physician, the matter should be raise by the division supervisor.
Where CPR has no potential benefit, at least 2 consult physicians (both Muslim) must agree on the diagnosis of a clear cut situation or in case of ample documented medical evidences plus family approval.
Once appropriate agreement is achieved, the family must be informed, in order to obtain full approval. It is the responsibility of the attending consultant physician caring for the case (once eligible for DNR) who should discuss the patient condition in details with the parents or relatives with special emphasis directed to the following issues:

- The natural history of the disease.
- The quality of the life of the patient if CPR is done.
- The possible effects of such situation on the patient himself, his siblings ad the family unity.
- The parents should be informed that the decision about DNR is a medical decision.
- The parents should be encouraged to share the decision or give unrestricted agreement to the medical decisions.

If approval is obtained DNR order shall be written on the patient's note and the appropriate DNR form to be used.
If advanced life support has been provided, start to withdraw the order
If advanced life support not started yet withhold them.
If there is any uncertainty in the minds of the treating physicians or disagreement between them and the patient or his relatives, the final decision is for the DNR Committee. The family has nothing to say in the DNR decision.

Reference to the fatwa No.12086 dated 30/6/1409H. In this context the relative can raise the matter to the Chief of Staff.
In the case of an emergency in which the antecedent state is uncertain, the principle, "Act first and evaluate later" shall prevail.
DNR decision shall not of itself preclude the continuation of basic treatment. The jurisdiction to discontinue other medical treatments and life requirements shall be decided upon specifically and separately from DNR orders.